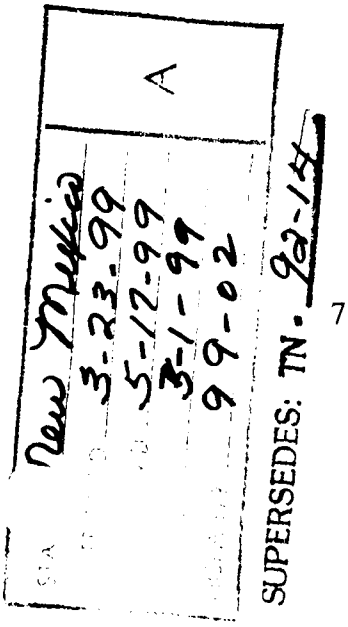
quarter.

d. For each subsequent plan year, the sole community hospital is required to submit to the Department, no later than January 15 for the subsequent state fiscal year, a sole community hospital payment request. If the hospital cannot meet the January 15 deadline, the hospital may submit a written request for up to a 30 day extension. Such requests must be received prior to the January 15 deadline.

e. The sole community provider payment request must be reviewed and approved by the county government in which the hospital is located. In order for the request to be valid, the county government's approval must be submitted with the hospital's request. If the hospital does not submit a valid request within the time frame identified above, it will not be eligible for a sole community provider adjustment for that year regardless of the hospital's status as a sole community hospital.

f. For years subsequent to the initial payment year, the sole community hospital payment adjustment will be the lessor of the amount paid by the Department pursuant to this section for the previous year trended forward using the market basket forecast published periodically in the HCFA Regional medical services letter or an amount mutually agreed upon by the hospital and the county government.

g. The Department will calculate the Medicare payment limit (specified at 42 CFR 447) annually. If the upper limit has not been exceeded, additional payments will be distributed by the Department. Should the amounts requested from the hospitals exceed the amount available under the upper limit the amounts will be prorated and distributed based on the amount of the requests received by the Department.



7. Indirect Medical Education (IME) Adjustment

Effective August 1, 1992, acute care hospitals that qualify as teaching hospitals will receive an indirect medical education (IME) payment adjustment, which covers the increase operating or patient care costs that are associated with approved intern and resident programs.

a. In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

1) Be licensed by the State of New Mexico;

2) Be reimbursed on a DRG basis under this plan; and

3) Have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

b. Determination of a hospital's eligibility for an IME adjustment will be done annually by the state, as of the first day of the provider's fiscal year. If a hospital meets the qualifications of an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualifications were met.

c. The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$$1.89*((1+R)^{.405}-1)$$

Where R equals the number of approved full-time equivalent residents divided by the number of available beds (excluding nursery beds). Full-time equivalent residents are counted in accordance with 42 CFR § 412.105(g). For the purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for Medicaid managed care enrollees if those persons had not been enrolled in managed care.

d. Quarterly IME payments will be made to qualifying hospitals at the end of each quarter. Prior to the end of each quarter, the provider will submit to the Department's audit agent the information necessary to make the calculation, i.e., number of beds, number of estimated residents for the quarter, and Medicaid DRG amount. After review and adjustment, if necessary, the audit agent will notify the Department of the amount due to/from the provider for the applicable quarter. Final settlement of the IME adjustment amount will be made through the cost report. That is, the number of beds, residents, and DRG amounts used in the quarterly calculations will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

8. Payment for Direct Graduate Medical Education (GME)

Effective for services provided on or after July 1, 1998, payment to hospitals for GME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments.

a. To be counted for Medicaid reimbursement, a resident must be participating in an approved residency program, as defined by Medicare in 42 CFR 413.86. With regards to categorizing residents, as described in paragraph b. of this section, the manner of counting and weighting resident FTEs will be the same as is used by Medicare in 42 CFR 413.86.

Resident FTEs whose costs will be reimbursed by the Department as a medical expense to a Federally Qualified Health Center are not eligible for reimbursement under this section.

To qualify for Medicaid GME payments, a hospital must be licensed by the State of New Mexico, be currently enrolled as a Medicaid provider, and must have achieved a Medicaid inpatient utilization rate of 5% or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the Medicaid inpatient utilization rate will be calculated as the ratio of New Mexico Medicaid eligible days, including inpatient days paid under Medicaid managed care arrangements, to total inpatient hospital days.

b. Approved resident FTEs are categorized as follows for Medicaid GME payment:

1) Primary Care/Obstetrics Resident. Primary care is defined per 42 CFR 413.86(b).

2) Rural Health Resident. A resident participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or

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clinic. Should any resident meet the criteria for both rural health and primary care in this section, this resident will be counted as a Rural Health resident.

3) Other approved resident. Any resident not meeting the criteria for categories 1 or 2, above.

c. Medicaid GME Payment Amount per Resident FTE

1) The annual Medicaid payment amount per Resident FTE for state fiscal year 1999 is as follows:

Primary Care/Obstetrics Resident:	$22,000
Rural Health Resident:	$25,000
Other Resident:	$21,000

2) The per resident amounts specified in paragraph 8.c.1 will be inflated for state fiscal years beginning on or after July 1, 1999 using the annual inflation update factor described in paragraph 8.d.2.

d. Annual Inflation Update Factor

Effective for state fiscal years 2000 and beyond, the Department will update the per resident GME amounts and the upper limit on GME payments for inflation, using the market basked forecast published in the HCFA Dallas Regional Medical Services letter issued for the quarter ending in March 1999 to determine the GME rates for state fiscal year 2000 (July 1, 1999-June 30, 2000).

The Department will use the market basket forecast shown for PPS hospitals that is applicable to the period during which the rates will be in effect. For example, the Department will use the forecast shown for July 1, 1999-June 30, 2000 to update the rates for state fiscal year 2000.

e. Annual Upper Limits on GME Payments

1) Total annual Medicaid GME payments will be limited to $5,800,000 for state fiscal year 1999. This amount will be updated for inflation, beginning with state fiscal year 2000, in accordance with paragraph 8.d.

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2) Total annual GME payments for residents in Category [redacted], "Other," will be limited to the following percentages of the $5,800,000 total annual limit (as updated for inflation in accordance with paragraph 8.d.).

State fiscal year 1999	58.3%
State fiscal year 2000	56.8%
State fiscal year 2001	53.3%
State fiscal year 2002	50.7%
State fiscal year 2003	48.0%
State fiscal year 2004	45.5%
State fiscal year 2005	43.0%
State fiscal year 2006	40.4%

f. Reporting and Payment Schedule

1) Hospitals will count the number of residents working according to the specification in this section during each fiscal year (July 1 through June 30) and will report this information to the Department by December 31. Counts will represent the weighted average number of residents who worked in the hospitals during the specified 12 month period. Hospitals may also add to this count any FTEs associated with newly approved residency programs that will be implemented on or before the start of the prospective GME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96-06/30/97 for the payment year [redacted]-06/30/99.
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The Department may require hospitals to provide documentation necessary to support the summary counts provided.

2) The Department will establish the amount payable to each hospital for the prospective payment period that will begin each July 1. Should total payments as initially calculated d. exceed either of the limitations in paragraph [redacted], the amount payable to each will be proportionately reduced.

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The annual amount payable to each hospital is divided in

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to four equal payments. These payments will be made by the Department on or about the start of each prospective payment quarter.

4) Should a facility not report timely with the accurate resident information as required in paragraph 1, above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in paragraph e., after prospective payment amounts to timely filing facilities have been established.

IV. DISPROPORTIONATE SHARE HOSPITALS

To take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs, a payment will be made to qualifying hospitals.

B. Criteria for Deeming Hospitals Eligible for a Disproportionate Share Payment

Determination of each hospital's eligibility for a disproportionate share payment for the Medicaid inpatient utilization rate as listed below, will be done annually by the department's audit agent, based on the hospital's most recently filed cost report. Hospitals which believe they qualify under the low income utilization rate must submit documentation justifying their qualification. This documentation should be submitted to the Department by March 31 of each year.

In the case of a DRG hospital with a PPS exempt specialty unit, data from the entire facility will be considered to determine DSH status.

The following criteria must be met before a hospital is deemed to be eligible:

1. Minimum Criteria

   a. The hospital must have:

      i. A Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state; or

      ii. A low-income utilization rate exceeding 25 percent. (Refer to subsection 2 for definitions of these criteria.)

   b. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under Medicaid. In the case of a hospital located in a rural area (defined as an area outside of a Metropolitan Statistical Area (MSA), as defined by the U.S. Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

   c. Subsection 1b does not apply to a hospital which meets the following criteria:

      i. The inpatients are predominantly individuals under 18 years of age; or

      ii. The hospital did not offer non-emergency obstetric services as of December 22, 1987.

   d. The hospital must have, at a minimum, a Medicaid inpatient utilization rate (MUR) of one percent.

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2. Definitions of Criteria

a. Medicaid inpatient utilization: For a hospital, the total number of its Medicaid inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period.

b. Low-income utilization rate: For a hospital, the sum (expressed as a percentage) of the following fractions:

i. The sum of total Medicaid inpatient and outpatient net revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of net revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

ii. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the amount of the cash subsidies received directly from the state and local governments in that period reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. If this number is zero or less than zero, then it is assumed to be zero. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid state plan), that is, reductions in charges given to other third-party payers, such as HMOs, Medicare, or Blue Cross.

c. The Medicaid utilization rate (MUR) is computed as follows:

MUR%=100xM/T

M= Hospital's number of inpatient days attributable to patients who for these days were eligible for Medical Assistance under the State Plan.

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T= Hospital's total inpatient days

Newborn days, days in specialized wards, and administratively necessary days are included in this calculation. Additionally, days attributable to individuals eligible for Medicaid in another state are included.

The numerator (M) does not include days attributable to Medicaid patients 21 or older in Institutions for Mental Disease (IMD) as these patients are not eligible for Medicaid coverage in IMDs under the New Mexico State Plan and cannot be considered a Medicaid day.

B. Inpatient Disproportionate Share Pools

Section 1923 of the Social Security Act allows qualifying hospitals to receive a disproportionate share payment, in addition to their allowable regular claims payments and any other payments to which they are entitled. This determination is performed annually as described in section IV.A. Qualifying hospitals will be classified in one of 3 disproportionate share hospital pools: Teaching PPS hospitals, non-teaching PPS hospitals, and PPS-exempt (TEFRA) hospitals. Hospitals may also qualify for a payment from a 4th pool: reserve pool, as explained in this section IV.C. below.

1. To qualify as a teaching hospital and be eligible for the teaching hospital DSH payment, the hospital must:

   a. Be licensed by the State of New Mexico; and

   b. Reimbursed, or be eligible to be reimbursed under the DRG basis under the plan; and

   c. Have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

2. A non-teaching PPS (DRG) hospital qualifies if it is an instate acute care hospital reimbursed by or eligible to be reimbursed by prospective payment methodology.

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